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ABSTRACT

Although informed consent has been incorporated into psychologists' ethical standards, it has been suggested that significant variation exists among therapists' practices and beliefs. To assess the current state of informed consent among therapists, American Psychological Association members (N=189) were surveyed. Counselors indicated their primary therapeutic orientation: eclectic, psychodynamic, cognitive-behavioral, systems, behavioral, existential, or humanistic. The survey limited the scope of informed consent to five specific issues: limits of confidentiality; potential risks of therapy; possible procedures to be used in therapy; and alternatives to therapy. Survey responses provided information on the percentage of clients informed of each issue, method of communication used, timing of presenting issues, extent of the issue's importance, and the reasons for not informing clients. The results indicated that when clients are typically informed of the consent issue therapists typically inform them during the initial session. Results suggest considerable variability in therapists' practices and beliefs. Therapists of a behavioral orientation were found to inform clients more often and consider the issues more important than other orientations. Since the majority of therapists reported informing at least some of their clients, awareness of the issues does not appear to be a major factor in whether one obtains informed consent. These findings, along with reasons given for not informing clients, highlight the complexity of applying ethical standards to a therapist's unique context. (ABL)

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Informed Consent: Therapists' Beliefs and Practices

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Abstract

Although informed consent has been incorporated into psychologists' ethical standards, it has been suggested that significant variation exists among therapists' practices and beliefs. To assess the current state of informed consent among therapists, a survey instrument was sent to 324 APA members currently practicing therapy. To obtain detailed information, the survey limited the scope of informed consent to five specific issues. Survey responses provided information on the percentage of clients informed of each issue, method of communication used, timing of presenting the issue, extent of the issue's importance, and the reasons for not informing clients of each issue. Results suggest considerable variability in therapists' practices and beliefs. In addition, therapists of a behavioral orientation were found to inform clients more often and consider the issues more important than other orientations. These findings, along with the reasons given for not informing clients, highlight the complexity of applying a ethical standards to a therapist's unique context. Implications for practice and needed research are discussed.

Informed Consent: Therapists' Beliefs and Practices

Research indicates substantial variability in therapist informed consent practices (Handelsman et al., 1986; Noll & Haugan, 1985). This variability has been seen in the choice of topics to include, how to inform clients, and when to inform them. These findings stand in contrast to an apparent consensus among psychologists in their support of the principle of informed consent. Noll and Haugan (1985) found in a sample of clinical directors that 86% agreed the doctrine of informed consent applies to psychotherapy. Indeed, responsibility to obtain informed consent has been incorporated into the APA's ethical standards (APA, 1990), and the current draft of the ethics code (APA, 1991) has provided additional coverage and detail to this topic. Though research cannot "settle" the discrepancy between professional standards and actual practice of informed consent, it can provide data regarding therapists' current beliefs and practices. In addition, by investigating informed consent in a practical setting, it is hoped that mediating contextual factors can be identified.

A basic investigation of therapists' practices and beliefs would involve an assessment of how often informed consent is obtained and how important therapists consider the issue.

While this information is essential, it does not address the informed consent process. The method of communicating information and the timing of presentation have been considered crucial to the consent process (Appelbaum, Lidz, & Meisel, 1987; Handelsman, et al.,1986; MacDevitt & Acker, 1990). Exploring such essential aspects of consent procedures would provide a closer look into the overall process.

Upon consideration of the variability in therapists' practices, the natural question of why therapists don't obtain informed consent arises. Widiger and Rorer (1984) allude to the complexities of integrating informed consent into particular therapeutic styles and interventions. Still others have warned of the potential negative impact of informed consent (e.g. restricting client disclosure, damaging the therapeutic relationship). In light of the growing number of studies that have not provided support for a possible negative impact (e.g. Handelsman, 1990; Goodyear, Coleman & Brunson, 1986), additional attention to therapists' concerns appear warranted.

The present survey research was designed to assess the status of informed consent in the therapeutic milieu. By focusing on only five informed consent issues, therapists had the opportunity to detail specific practices and express their beliefs.

Method

Participants

With the assistance of the APA's Office of Demographic, Employment, and Educational Research, 324 psychologists were selected. The population of interest was psychologists currently seeing clients in therapy. The participants were randomly selected from a population of doctoral level APA members engaging in health and mental health activities. From the sample, 189 completed surveys were returned; 27 participants reported not currently seeing clients; 2 had not yet received their doctoral degree, for a total return rate of 67.3%. The mean age of participants was 44.8 years (SD= 9.1). For number of years since receiving the doctoral degree, the mean and median were 13.5 (SD=8.9) and 12.2 years, respectively. The sample was 54% male and 46% female. Participants' professional speciality in psychology was reported as clinical (95.1%; n=173), counseling (3.8%; n=7), and neuropsychology (1.1%; n=2). Their primary work setting was divided among private practice (66.1%; n=123), community mental health (6.5%; n=12), veterans hospital (4.8%; n=9), general hospital (4.8; n=9), university/college counseling center (4.3%; n=8), , psychiatric hospital (3.8%; n=7), and others (9.7; n=18). Finally, the largest number of participants indicated their primary therapeutic orientation as eclectic

(36.3%; n=66) followed by psychodynamic (28.0%; n=51), cognitive-behavioral (23.1%; n=42), systems (5.5%; n=10), behavioral (2.7; n=5), existential (2.2%; n=4) and humanistic (2.2%; n=4).

Instrument

A survey instrument was designed to assess therapists' beliefs and practices regarding informed consent. Research questions concerned five specific consent issues: (a) limits of confidentiality; (b) potential risks of therapy; (c) expected length of therapy; (d) possible procedures to be used in therapy; and, (e) alternatives to therapy. These five issues were chosen based upon their prominence in the informed consent literature (e.g. Hare-Mustin, et al.,1979; Thompson, 1990) and the ethical standards (including proposed revisions). The literature also suggests a lack of professional consensus regarding these issues' inclusion and implementation in the informed consent process (Noll & Haugan, 1985; Handelsman, et al., 1986)

For each consent issue, five questions were asked. The first question assessed the extent to which the issue is included in the participants' practice. They were asked to indicate what percentage of their clients are informed of the issue. The choices were six percentage ranges: 100%, 75%-99%, 50%-74%,25%-49%,1%-24%, 0%.

The second question assessed the extent to which the participants feel that each issue is important. The alternatives were: 1= not important, 2= slightly important, 3= moderately important, and 4= very important.

The third question was designed to obtain therapists' beliefs as to why they do not address the specific consent issue with a client (This question was omitted by participants informing 100% of their clients). For each issue, the participants were asked to list up to three of their most important reasons for not including the issue.

The fourth question concerned the method of communication typically used to inform clients. The multiple-choice answers included written form, verbal discussion, and audio/videotape. Participants were asked to indicate the method or combination of methods typically used. Past research (Noll & Haugan,1985) has not included the option of audio/videotape. In light of the prevalence of this technology, it seemed prudent to include it.

The final question for each issue dealt with the therapists' timing of the consent procedure. A multiple-choice format offered the following options: prior to therapy, during the first session, during the second or third session, during the fourth and subsequent sessions, and only when the issue arises.

An information section asked participants to identify their age, gender, and the number of years since obtaining their doctoral degree. They were also requested to indicate their professional speciality in psychology, primary therapeutic orientation, and primary work setting. The alternatives of therapeutic orientations were developed in consideration of a national survey of psychologists' orientations by Norcross and Prochaska (1982) and another by Zook and Walton (1989). Work settings were also determined by drawing on the findings of these two surveys.

Procedure

The 324 persons in the sample were sent (a) a 1-page cover letter, (b) the survey instrument, and (c) a stamped, addressed return envelope. One week after the original mailing, a reminder postcard was sent. Follow-up surveys were sent to nonrespondents at 3 and 7 weeks after the original mailing. A numerical code system was used to insure confidentiality.

Results

The survey responses to the questions of belief of importance, percentage of clients informed, method of communication and timing of presentation are presented in Table 1.

Insert Table 1 about here

Statistical analyses focused on each specific consent issue as well as differences across issues. The responses to the open-ended item regarding the reasons for not informing clients were analyzed by content analysis. For each issue, concrete responses were sorted into six to eight categories based on logical and conceptual similarity. Two research assistants (doctoral students in counseling psychology) independently sorted all responses into the category system. Interrater reliabilities for each issue ranged from K=.75 to .86.

Regarding the extent to which participants believe it is important to inform clients of each issue, descriptive analysis revealed that limits of confidentiality was considered very important by the majority of respondents (80.2%). The degree of importance for the other four issues were more evenly distributed among slightly, moderately, and very important. A repeated measures ANOVA revealed a significant difference, $F(4, 840)= 32.85$, $p< .0001$, between these five issues. A follow-up analysis using Tukey's Studentized Range (HSD) revealed that participants considered informing clients of the limits of confidentiality significantly more important ($M=3.7$) than the four other issues In addition, participants considered informing clients of the possible procedures to be used as

significantly more important (M= 3.1) than potential risks (M= 2.8 and alternatives to therapy (M= 2.8).

The question concerning the percentage of clients informed of each of the five issues produced a varied distribution. While certain issues had a majority of responses in the 75% and higher range (e.g., possible procedures), other issues had a more even distribution across the percentage ranges (e.g., alternatives to therapy). A repeated measures ANOVA revealed a significant difference, $F(4,865)= 33.09$, $p<.0001$, among the five issues. A Tukey's Studentized Range (HSD) follow-up test indicated that the percentage of clients informed of limits of confidentiality and possible procedures are significantly greater than clients informed of the other three issues. In addition, the percentage of clients informed of length of therapy was found to be significantly greater than potential risk and alternatives to therapy, but less than limits of confidentiality and possible procedures. Finally, the percentage of clients informed of potential risks and alternative to therapy were significantly less than length of therapy, possible procedures, and limits of confidentiality.

To assess a possible relationship between participants' beliefs about the importance of the issues and the percentage of clients they inform of the issue, correlations were computed between these variables. Correlations of .60, .59,

.56, .47, and .40, suggest a moderately significant relationship for each of the five issues.

Responses to the method of communication typically used for informed consent procedures suggest a strong preference for participants to typically use verbal discussion (see Table 1). This preference ranged from 53.8% for limits of confidentiality to 88.5% for alternatives to therapy. The next most frequently cited method was using verbal discussion and written form (ranging from 4.8% for length of treatment to 28.8% for limits of confidentiality). Audio/videotape was cited only once out of 182 responses.

Responses when clients are typically informed of the consent issue, indicate that therapists' typically inform clients during the initial session. The issue of limits of confidentiality provided the only exception to this finding, with clients typically being informed prior to the beginning of therapy (59.8%). The next most frequent responses were, only when the issue arises (ranging from 10.9% for limits of confidentiality to 26.1% for potential risks of therapy) and prior to the beginning of therapy (ranging from 11.8% for possible procedures to 23.0% for alternatives to therapy).

The reasons given for not informing clients of an issue are presented in Table 2.

Insert Table 2 about here

While some issues reported a fairly even distribution of responses across categories (e.g., alternatives to therapy), other issues had more prevalent reasons. As an example, the reason "can't predict or don't know length of treatment" was cited 52.2% (n=95) of the time for the issue of length of therapy. In regards to the issue of possible procedures to be used, the reason of "unable to identify or determine procedures" was provided 25.8% of the time. While some reasons seemed specific to the particular issue (e.g., "risks are considered minimal or none"), other reasons were cited across several issues. The reason of "not relevant or necessary" was cited for all five issues, and was the most frequent response for the issues of limits of confidentiality and alternatives to therapy. Other reasons cited across several issues were negative impact to client/therapeutic relationship, client already knows of the issue, and client wouldn't understand.

Theoretical Orientation

Theoretical orientation was analyzed in relation to the question concerning the belief in the extent of the issues' importance. Due to small group sizes of some orientations, the analyses were conducted on the categories of cognitive-behavioral (including behavioral), eclectic, and psychodynamic. A MANOVA, using a Wilks' Lambda critical value of .05,

revealed a significant amount of variation as a function of orientation, $F(10, 282)= 2.32$, $p<.012$. A Tukey's follow-up test indicated that cognitive-behavioral participants believed it was significantly more important ($M=3.04$) to inform clients of alternatives to therapy than psychodynamic participants ($M= 2.5$). In addition, cognitive-behavioral participants indicated that informing clients of length of treatment was significantly more important ($M= 3.4$) than was indicated by eclectic ($M= 2.7$) and psychodynamic ($M= 2.7$) orientations.

Theoretical orientation was also analyzed as a potentially significant variable for the items of percentage of clients informed. Using the three orientations of cognitive-behavioral, eclectic and psychodynamic, a MANOVA with a Wilks' Lambda critical value of .05, revealed a significant difference, $F(10,288)= 2.19$, $p<.018$. A Tukey's follow-up found that participants of a cognitive-behavioral orientation informed significantly more clients about alternatives to therapy and length of treatment than either eclectic or psychodynamic participants. Theoretical orientation in relation to timing and method of communicating consent issues were not considered due to small cell size. Finally, analysis of the variables of work setting, number of years since receiving degree and sex, revealed no significant findings.

Discussion

The percentage of clients informed of the five consent issues, highlight the variability among therapists' practices. Such findings support the claim by Pope, Tabachnick & Keith-Spiegel (1987), that behavioral norms are not the same as ethical standards. This distribution across the percentage ranges may be indicative of the complexities and mediating factors involved in the decision to obtain informed consent for a particular issue. The data moderately support the conclusion that therapists' practices are in accordance with their belief of importance. This is consistent with past research on a wide range of ethical issues (Pope et al., 1987). In light of the significant variability, much can be learned from focusing on therapists that do not always inform clients.

Since the majority of therapists report informing at least some of their clients, awareness of the issue does not appear to be major factor in whether one obtains informed consent. The reasons given for not informing clients also provides some insight into therapists belief of an issue's importance. A reason such as, issue is not necessary or client is not interested, may be indicative of the therapists' perceived importance of the issue. The reason of, client is already aware of the issue, was given for four of the five issues. In lieu of careful assessment of client knowledge, this

reason may be suggestive of the priority given to informed consent.

Along with the impact of the perceived importance or relevancy of an issue, reasons such as the negative impact on the client/therapeutic relationship stress the concerns of applying informed consent within the therapeutic context. While recent findings have not substantiated these concerns (Handelsman, 1990), they nevertheless appear to impact the practice of some therapists.

While informed consent has been discussed as a complete entity (Appelbaum, Lidz & Meisel, 1987), these results suggest significant differences among the issues. Therapists' inform clients of certain issues more than others and believe certain issues are more important. In addition, specific reasons for not informing of an issue, highlight the unique characteristics of a particular issue. For example, risks are minimal or none and specific procedures aren't used, point to the individual dynamics of a specific issue.

The method typically used to inform clients of the issues was verbal discussion. This method would appear to be advantageous for (a) assessing clients' comprehension, (b) addressing questions and concerns, and (c) collaborative decision making. However, in light of documentation and liability concerns, it seems surprising that there is not

greater use of written or a combination of written and verbal methods.

The earliest time that clients are typically informed of an issue seems to be during or before the initial session. While this might appear to be the ideal time frame for presentation, contextual factors might argue for greater flexibility in the timing. The reasons for not informing of an issue, such as, risks are unclear, can't predict length of therapy and unable to identify procedures seem especially valid if consent must be obtained in the first session. How can therapists provide information that is not available? Appelbaum, Lidz and Meisel (1987) provide a context for this discussion with their outline of two models of informed consent. The "event" model, proposes that necessary information is presented at a single point in time. The "process" model views the informed consent as a continuous, interactive process. While the survey did not specifically address which model therapists utilize, therapists reasons that focus on not having a definitive answer, appear to be within a context of one time, "event" model.

The finding that therapists with a behavioral orientation inform more clients of consent issues and believe the issues are more important, stimulates several hypotheses. One explanation is that behavioral therapists may be more ethical

than their eclectic or psychodynamic counterparts. However, the psychodynamic therapist would quickly refer to the findings by Boyrs and Pope (1989) that psychodynamic psychologists affirmed the unethical nature of dual relationships to a significantly greater extent than their colleagues. One hypothesis is that the specific issues considered in this study were more applicable or well-defined when considered in a behavioral context.

The discussion of consent issues may also reflect the nature of each orientation's perception of the therapeutic relationship. It seems plausible that informed consent may be more relevant to a collaborative-oriented relationship than a doctor-patient relationship. Widiger and Rorer (1984) suggest that it is not possible to have one set of ethical standards that are compatible with all therapeutic orientations.They recommend a relativistic resolution, whereby each therapist creates their own set of ethical principles, unique to their individual orientation. While this suggestion solves the issue of compatibility, the welfare of the client seems to become of secondary importance.

Although careful attention to confidentiality was maintained, assessing therapists' ethical practices and beliefs is susceptible to "fake good" responses. A discrepancy between self-report and actual practice presents a potential limitation of this type of research. It is also important to note that the sample of therapists

did not include such specialities as school psychologists. Finally, the study was not able to consider variables such as the level of ethics training for each participant. This factor may have important implications for future research and education

Conclusions

The variability among therapists' practices and beliefs suggests that a focus on ethical standards may not be enough. Ethical standards need to be considered within the unique context of the therapist. This context includes the therapist's values, orientation, and work setting. For example, informing clients of the length of therapy would appear to be incompatible within the context of a psychodynamic orientation. The principles of respecting autonomy and benefiting others would seem to be in conflict. This example highlights the difficult task of applying ethical standards and principles to one's particular context. It seems essential that therapists continue to struggle with these dilemmas.

Some of the reasons given for not informing clients, appear to reflect a concern for the welfare of the client. More research is needed regarding the positive and negative impact of informed consent, to assist therapists in their ethical decision making. Still, other reasons seem to indicate that informed consent is not considered relevant, important or just of low priority. Hence, the value placed on informed consent becomes a central issue in regards to practice. The value given informed consent can be

fostered through ethics education, graduate training and professional discussion.

The variability in practice issues and the significant differences among consent issues, highlights the complexity of the informed consent process. While creating new standards for psychologists, consideration of the difficult challenge of implementation appears essential.

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current perspective. Professional Psychology: Research and Practice, 20 (1), 23-31.

Table 1

Percentage of Therapists Responding to Practice Issues and Perceived Importance

	Limits of Confidentiality	Potential risks of therapy	Length of treatment	Possible procedures to be used	Alternatives to therapy
Degree of importance					
very important	80.2	26.9	26.4	41.1	25.0
moderately important	11.5	35.4	46.6	35.0	34.7
slightly important	6.6	25.7	20.8	21.1	33.0
not important	1.6	12.0	6.2	2.8	7.4
Percentage of clients informed					
100%	59.5	22.2	31.6	56.4	28.1
75-99%	13.5	14.4	26.7	19.1	16.2
50-74%	9.7	10.6	16.6	10.1	10.3
25-49%	3.8	8.9	10.7	5.9	11.9
1-24%	10.8	25.6	8.0	7.4	26.5
0%	2.2	18.3	6.4	1.1	7.0
How clients are typically informed					
Verbal discussion	53.8	70.7	87.6	85.7	88.5
Written form	14.7	6.6	2.7	2.7	1.1
Verbal discussion and written form	28.8	5.5	4.8	7.7	5.5
Audio/videotape	0.0	0.0	0.0	0.5	0.0
Verbal discussion and audio/videotape	0.0	0.0	0.0	1.1	0.0
Clients are not informed of the issue	2.7	17.1	4.8	2.2	4.9
When clients are typically informed					
Prior to the beginning of therapy	59.8	13.6	11.8	19.5	23.0
During the initial session	13.6	44.3	55.3	55.6	39.8
During the second or third sessions	9.8	6.8	10.6	8.9	7.5
During the fourth or subsequent sessions	3.8	0.0	3.5	1.8	1.2
Only when the issue arises	10.9	26.1	17.6	14.2	25.5
Clients are not informed	2.2	9.1	1.2	0.0	3.1

Note: N's used in computing percentages ranged from 161-185.

Table 2

Therapists' Reasons For Not Informing Clients of Consent Issues

Issue	percentage	(frequency)
Limits of Confidentiality		
1. Issue is not relevant or necessary	37.5	(45)
2. Forget	15.8	(19)
3. Client already has knowledge of the issue	13.3	(16)
4. Negative impact to client and/or therapeutic relationship	9.2	(11)
5. Clients are unable to understand	7.5	(9)
6. Other	16.7	(20)
Potential Risks of Therapy		
1. Risks are considered minimal or none	25.5	(47)
2. Issue is not relevant or necessary	24.5	(45)
3. Negative impact on client and/or therapeutic relationship	13.6	(25)
4. Risks are unknown or unclear	10.3	(19)
5. Client is already aware of risks	6.0	(11)
6. Forget	4.3	(8)
7. Client is unable to understand	2.7	(5)
8. Other	13.0	(24)
Length of Treatment		
1. Can't predict or don't know length	52.2	(95)
2. Issue is not considered necessary	8.8	(16)
3. Negative impact to client and/or therapeutic relationship	7.7	(14)
4. Therapy is long-term	5.5	(10)
5. Client does not bring up the issue	5.5	(10)
6. Forget	3.8	(7)
7. Client is not interested or concerned	3.3	(6)
8. Other	13.2	(24)
Possible Procedures To Be Used		
1. Unable to identify/determine procedures	25.8	(25)
2. Client is already aware of procedures	16.5	(16)
3. Client is not or does not show interest	12.4	(12)
4. Issue is not relevant or necessary	11.3	(11)
5. Specific procedures are not used	10.3	(10)
6. Client wouldn't understand	6.2	(6)
7. Other	17.5	(17)
Alternatives to Therapy		
1. Issue is not relevant or necessary	19.7	(29)
2. Lack of alternatives	17.7	(26)
3. Implicit that they want what is provided	15.0	(22)
4. Therapy is the preferred choice	15.0	(22)
5. Client already knows or has considered alternatives	12.2	(18)
6. Unclear of possible alternatives	2.4	(3)

Note: Total reasons listed, and used as the denominator in computing percentages, were 120 for limits of confidentiality, 184 for potential risks of therapy, 182 for length of treatment, 97 for possible procedures to be used, and 147 for alternatives to therapy.